		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045815

Facility Name: Chicago Ridge Nursing Center

Address: 10602 Southwest Highway (Number) Chicago Ridge (City) 60415 (Zip Code)

County: Cook

Telephone Number: (773) 252-3208 **Fax #** (773) 252-3688

IDPA ID Number: 364420067

Date of Initial License for Current Owners: 11/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford B Alper **Telephone Number:** (847) 580-4100

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Sanford B Alper - Principal

(Firm Name & Address) Kessler, Orlean, Silver & Company, P.C.
1101 Lake Cook Rd, Suite C, Deerfield, Illinois 60015

(Telephone) (847) 580-4100 Fax # (847) 580-4199

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 231

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	231	Intermediate (ICF)	231	84,546	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	231	TOTALS	231	84,546	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	57,592	4,144	5,629	67,365	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,592	4,144	5,629	67,365	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.68%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 38 and days of care provided 3,181

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,407	31,093	9,200	249,700		249,700	17,691	267,391			1
2	Food Purchase		229,473		229,473		229,473	(333)	229,140			2
3	Housekeeping	146,276	18,748		165,024		165,024		165,024			3
4	Laundry	76,486	14,633		91,119		91,119		91,119			4
5	Heat and Other Utilities			170,002	170,002		170,002	3,207	173,209			5
6	Maintenance	23,985	41,212	3,482	68,679		68,679	106,794	175,473			6
7	Other (specify):* See Attached Sch			15,646	15,646		15,646		15,646			7
8	**TOTAL General Services**	456,154	335,159	198,330	989,643		989,643	127,359	1,117,002			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,827,680	38,737	14,242	1,880,659		1,880,659	242	1,880,901			10
10a	Therapy	15,008		6,969	21,977		21,977		21,977			10a
11	Activities	84,114	1,630		85,744		85,744		85,744			11
12	Social Services	66,541	35,332	4,730	106,603		106,603		106,603			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,993,343	75,699	25,941	2,094,983		2,094,983	242	2,095,225			16
	C. General Administration											
17	Administrative			517,984	517,984		517,984	(314,182)	203,802			17
18	Directors Fees											18
19	Professional Services			59,039	59,039		59,039	(1,304)	57,735			19
20	Dues, Fees, Subscriptions & Promotions			39,466	39,466		39,466	(8,476)	30,990			20
21	Clerical & General Office Expenses	45,691		29,359	75,050		75,050	155,871	230,921			21
22	Employee Benefits & Payroll Taxes			342,024	342,024		342,024	27,092	369,116			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,360	1,360		1,360		1,360			24
25	Other Admin. Staff Transportation			240	240		240	177	417			25
26	Insurance-Prop.Liab.Malpractice			288,827	288,827		288,827	1,140	289,967			26
27	Other (specify):* Marketing	5,538			5,538		5,538	(5,538)				27
28	**TOTAL General Administration**	51,229		1,278,299	1,329,528		1,329,528	(145,220)	1,184,308			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,500,726	410,858	1,502,570	4,414,154		4,414,154	(17,619)	4,396,535			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Chicago Ridge Nursing Center #0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			16,142	16,142		16,142	(7,209)	8,933			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					448,253	448,253		448,253			33
34	Rent-Facility & Grounds			1,537,236	1,537,236	(448,253)	1,088,983		1,088,983			34
35	Rent-Equipment & Vehicles			3,360	3,360		3,360	636	3,996			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,556,738	1,556,738		1,556,738	(6,573)	1,550,165			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,795	123,835	195,630		195,630		195,630			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,819	126,819		126,819		126,819			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		71,795	250,654	322,449		322,449		322,449			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,500,726	482,653	3,309,962	6,293,341		6,293,341	(24,192)	6,269,149			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,411)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(333)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(525)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,486)	20		28
29	Other-Attach Schedule	(11,437)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (24,192)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (24,192)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Chicago Ridge Nursing Center

ID# 0045815

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Franchise Tax	$ (250)	21	1
2	Franchise Tax from Management Company	(25)	21	2
3	Marketing Salaries	(5,538)	27	3
4	Collections	(1,432)	19	4
5	Non Deductible Dues	(4,192)	20	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(11,437)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	17,691	0	0	0	0	0	0	0	0	17,691	1
2	Food Purchase	(333)	0	0	0	0	0	0	0	0	0	0	(333)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,207	0	0	0	0	0	0	0	0	0	3,207	5
6	Maintenance	0	1,244	105,550	0	0	0	0	0	0	0	0	106,794	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(333)	4,451	123,241	0	0	0	0	0	0	0	0	127,359	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	242	0	0	0	0	0	0	0	0	242	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	242	0	0	0	0	0	0	0	0	242	16
	C. General Administration													
17	Administrative	0	0	(314,182)	0	0	0	0	0	0	0	0	(314,182)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,432)	128	0	0	0	0	0	0	0	0	0	(1,304)	19
20	Fees, Subscriptions & Promotions	(8,678)	202	0	0	0	0	0	0	0	0	0	(8,476)	20
21	Clerical & General Office Expenses	(800)	537	156,134	0	0	0	0	0	0	0	0	155,871	21
22	Employee Benefits & Payroll Taxes	0	27,092	0	0	0	0	0	0	0	0	0	27,092	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	177	0	0	0	0	0	0	0	0	177	25
26	Insurance-Prop.Liab.Malpractice	0	1,140	0	0	0	0	0	0	0	0	0	1,140	26
27	Other (specify):*	(5,538)	0	0	0	0	0	0	0	0	0	0	(5,538)	27
28	**TOTAL General Administration**	(16,448)	29,099	(157,871)	0	0	0	0	0	0	0	0	(145,220)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,781)	33,550	(34,388)	0	0	0	0	0	0	0	0	(17,619)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(7,411)	0	202	0	0	0	0	0	0	0	0	(7,209)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	636	0	0	0	0	0	0	0	0	0	636	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,411)	636	202	0	0	0	0	0	0	0	0	(6,573)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(24,192)	34,186	(34,186)	0	0	0	0	0	0	0	0	(24,192)	45

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Balmoral Home, Inc.	Chicago, IL	Nivram Mngt, Inc.	Lincolnwood, IL	Management
Joseph Mermelstein Trust	25.00%	Central Nursing Home, Inc.	Chicago, IL			
Barry Taerbaum	25.00%	Sovereign Healthcare, L.L.C.	Chicago, IL			
		RREM Inc. D/B/A Winston Manor Nursing Home	Chicago, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank Charges	$	Nivram Management, Inc.	50.00%	$ 24	$ 24	1
2	V	21	Office Expenses		Nivram Management, Inc.	50.00%	488	488	2
3	V	20	Dues & Subscriptions		Nivram Management, Inc.	50.00%	202	202	3
4	V	21	Franchise Tax		Nivram Management, Inc.	50.00%	25	25	4
5	V	19	Accounting Fees		Nivram Management, Inc.	50.00%	128	128	5
6	V	22	Payroll Taxes		Nivram Management, Inc.	50.00%	23,840	23,840	6
7	V	5	Utilities		Nivram Management, Inc.	50.00%	3,207	3,207	7
8	V	26	Insurance Expense		Nivram Management, Inc.	50.00%	1,140	1,140	8
9	V	6	Repairs & Maintenance		Nivram Management, Inc.	50.00%	776	776	9
10	V	22	Health Insurance		Nivram Management, Inc.	50.00%	3,252	3,252	10
11	V	6	Scavenger		Nivram Management, Inc.	50.00%	93	93	11
12	V	35	Rental Equipment		Nivram Management, Inc.	50.00%	636	636	12
13	V	6	Building Expense		Nivram Management, Inc.	50.00%	375	375	13
14	Total			$			$ 34,186	$ * 34,186	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto Expense	$	Nivram Management, Inc.	50.00%	$ 177	$ 177	15
16	V	21	Postage		Nivram Management, Inc.	50.00%	474	474	16
17	V	10	Matress Expense		Nivram Management, Inc.	50.00%	242	242	17
18	V	30	Depreciation		Nivram Management, Inc.	50.00%	202	202	18
19	V	21	Data Processing		Nivram Management, Inc.	50.00%	479	479	19
20	V	21	Telephone		Nivram Management, Inc.	50.00%	1,309	1,309	20
21	V	6	Plant Salary		Nivram Management, Inc.	50.00%	27,250	27,250	21
22	V	17	Assistant Administrator Salary		Nivram Management, Inc.	50.00%	40,874	40,874	22
23	V	21	Office Manager Salary		Nivram Management, Inc.	50.00%	18,356	18,356	23
24	V	1	Food Service Supervisor Salary		Nivram Management, Inc.	50.00%	17,691	17,691	24
25	V	17	Administrative Salaries		Nivram Management, Inc.	50.00%	59,274	59,274	25
26	V	17	Administrator Salaries		Nivram Management, Inc.	50.00%	103,654	103,654	26
27	V	21	Clerical Salaries		Nivram Management, Inc.	50.00%	135,516	135,516	27
28	V	6	Maintenance Salary		Nivram Management, Inc.	50.00%	78,300	78,300	28
29	V	17	Management Fees	517,984	Nivram Management, Inc.	50.00%		(517,984)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 517,984			$ 483,798	$ * (34,186)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Henry Mermelstein	Administrative	Administrative	0.00%	215,979	11	14.00	Salary	$ 34,021	17-7	1
2	Louise Mermelstein	Food Service Supp.	Food Service Sup	0.00%	72,309	14	17.00	Salary	17,691	1-7	2
3	Marvin Mermelstein	Plant Supervisor	Support	50.00%	81,750	5	25.00	Salary	27,250	6-7	3
4	Doreen Mermelstein	Office Manager	Administrative	0.00%	85,764	6	10.00	Salary	18,356	21-7	4
5											5
6	Marvin Mermelstein	Asst. Administrative	Administrative	See Above	122,626	7	25.00	Salary	40,874	17-7	6
7	Joseph Mermelstein	Owner	Administrative	25.00%	69,747	3	27.00	Salary	25,253	17-7	7
8	Barry Taerbaum	Owner	Administrative	25.00%	282,197	4	11.00	Salary	35,000	17-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 198,445		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Ave.
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	924	5	$ 110	$	231	$ 24	1
2	21	Office Expenses	Resident Beds	924	5	1,952		231	488	2
3	20	Dues & Subscriptions	Resident Beds	924	5	810		231	202	3
4	21	Franchise Tax	Resident Beds	924	5	100		231	25	4
5	19	Accounting Fees	Resident Beds	924	5	510		231	128	5
6	22	Payroll Taxes	Resident Beds	924	5	95,359		231	23,840	6
7	5	Utilities	Resident Beds	924	5	12,827		231	3,207	7
8	26	Insurance Expense	Resident Beds	924	5	4,558		231	1,140	8
9	6	Repairs & Maintenance	Resident Beds	924	5	3,103		231	776	9
10	22	Health Insurance	Resident Beds	924	5	13,008		231	3,252	10
11	6	Scavenger	Resident Beds	924	5	370		231	93	11
12	35	Rental Equipment	Resident Beds	924	5	2,544		231	636	12
13	6	Building Expense	Resident Beds	924	5	1,500		231	375	13
14	25	Auto Expense	Resident Beds	924	5	706		231	177	14
15	21	Postage	Resident Beds	924	5	1,895		231	474	15
16	10	Matress Expense	Resident Beds	924	5	967		231	242	16
17	30	Depreciation	Resident Beds	924	5	808		231	202	17
18	21	Data Processing	Resident Beds	924	5	1,914		231	479	18
19	21	Telephone	Resident Beds	924	5	5,238		231	1,309	19
20	6	Plant Salary	Direct Cost	1	1	27,250	27,250	1	27,250	20
21	17	Assistant Administrator Salary	Direct Cost	1	1	40,874	40,874	1	40,874	21
22	21	Office Manager Salary	Direct Cost	1	1	18,356	18,356	1	18,356	22
23	1	Food Service Supervisor Salary	Direct Cost	1	1	17,691	17,691	1	17,691	23
24	17	Administrative Salaries	Direct Cost	1	1	59,274	59,274	1	59,274	24
25	TOTALS					$ 311,724	$ 163,445		$ 200,514	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 6500 N. Hamlin Ave.
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 679-7484
Fax Number: (847) 679-7494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrator Salaries	Direct Cost	1	1	$ 133,654	$ 133,654	1	$ 133,654	1
2	21	Clerical Salaries	Direct Cost	1	1	105,516	105,516	1	105,516	2
3	6	Maintenance Salary	Direct Cost	1	1	78,300	78,300	1	78,300	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 317,470	$ 317,470		$ 317,470	25

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ (112,229)	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 386,084	2
3. Under or (over) accrual (line 2 minus line 1).		$ 498,313	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ (50,060)	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 448,253	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	331,718	8
	2000	344,809	9
	2001	358,079	10
	2002	374,839	11
	2003	386,154	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Chicago Ridge Nursing Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0045815

CONTACT PERSON REGARDING THIS REPORT Sanford B Alper

TELEPHONE (847) 580-4100 FAX #: (847) 580-4199

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-18-101-025-0000	Nursing Home	$ 283,600.72	$ 283,600.72
2.	24-18-101-039-0000	Nursing Home	$ 102,553.03	$ 102,553.03
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 386,153.75	$ 386,153.75

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 87,480 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3 + Basement

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	73,980		$	1
2					2
3	TOTALS	73,980		$	3

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			2001	1,419	37	39	37		114	9
10	Carpet			2002	2,240	57	39	57		144	10
11	Alarm			2002	22,000	564	39	564		1,410	11
12	Washer & Dryers			2002	29,304	751	39	751		1,879	12
13	Phone System			2002	10,667	273	39	273		684	13
14	A/C System			2002	11,200	287	39	287		718	14
15	Electrical Improvement			2002	3,000	77	39	77		192	15
16	Light Fixtures			2002	10,192	262	39	262		654	16
17	RC Alarm			2003	4,500	115	39	115		202	17
18	Water Heater			2003	16,500	6,270	39	423	(5,847)	846	18
19	Boiler			2004	21,500		39	551	551	551	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 132,522	$ 8,693		$ 3,397	$ (5,296)	$ 7,394	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 47,322	$ 6,969	$ 4,732	$ (2,237)	10	$ 13,559	71
72	Current Year Purchases	2,400	480	240	(240)	10	240	72
73	Fully Depreciated Assets							73
74	Management Company		202	564	362	10	1,034	74
75	TOTALS	$ 49,722	$ 7,651	$ 5,536	$ (2,115)		$ 14,833	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 182,244	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 16,344	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 8,933	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,411)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 22,227	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		231	11/01/01	$ 1,537,236	30	30	3
4	Additions							4
5								5
6								6
7	TOTAL		231		$ 1,537,236 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/01
Ending 10/31/31

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2005	$ 1,601,705
13.	12/31/2006	$ 1,643,862
14.	12/31/2007	$ 1,657,915

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 3,996 Description: Copier - $3,360; Allocation from Nuvram (Copier) - $636.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			123,835			123,835	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				43,789		43,789	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Attached Sch	39-2					28,006		28,006	13
14	TOTAL			$		$ 123,835	$ 71,795		$ 195,630	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 30,912	$ 30,912	1
2	Cash-Patient Deposits	19,967	19,967	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	937,783	937,783	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	128,401	128,401	6
7	Other Prepaid Expenses	281,542	281,542	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	131,397	131,397	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,530,002	$ 1,530,002	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	86,718	86,718	15
16	Equipment, at Historical Cost	94,539	94,539	16
17	Accumulated Depreciation (book methods)	(46,432)	(46,432)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 134,825	$ 134,825	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,664,827	$ 1,664,827	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 25,584	$ 25,584	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,320	23,320	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,012	81,012	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,008,093	1,008,093	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,138,009	$ 1,138,009	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,138,009	$ 1,138,009	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 526,818	$ 526,818	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,664,827	$ 1,664,827	48

*(See instructions.)

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,334,876	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,334,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,066,942	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,875,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (808,058)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 526,818	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,254,014	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,254,014	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	43,873	6
7	Oxygen	26,061	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 69,934	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,333	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 36,333	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,360,283	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	989,643	31
32	Health Care	2,094,983	32
33	General Administration	1,329,528	33
	B. Capital Expense		
34	Ownership	1,556,738	34
	C. Ancillary Expense		
35	Special Cost Centers	195,630	35
36	Provider Participation Fee	126,819	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,293,341	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,066,942	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,066,942	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,240	1,240	$ 45,017	$ 36.30	1
2	Assistant Director of Nursing	2,564	2,656	70,268	26.46	2
3	Registered Nurses	9,569	9,573	253,010	26.43	3
4	Licensed Practical Nurses	32,781	33,261	713,003	21.44	4
5	Nurse Aides & Orderlies	73,725	76,168	676,154	8.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,876	1,876	15,008	8.00	8
9	Activity Director	1,467	1,467	19,321	13.17	9
10	Activity Assistants	7,629	7,816	64,793	8.29	10
11	Social Service Workers	6,103	6,206	66,541	10.72	11
12	Dietician					12
13	Food Service Supervisor	2,622	2,670	32,096	12.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,136	23,090	177,311	7.68	15
16	Dishwashers					16
17	Maintenance Workers	2,383	2,423	23,985	9.90	17
18	Housekeepers	20,662	21,431	146,276	6.83	18
19	Laundry	9,807	10,322	76,486	7.41	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,485	5,573	45,691	8.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,000	4,000	70,228	17.56	31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	200	200	5,538	27.69	33
34	TOTAL (lines 1 - 33)	204,249	209,972	$ 2,500,726 *	$ 11.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 9,200	1-3	35
36	Medical Director	O			36
37	Medical Records Consultant	N	12,181	10-3	37
38	Nurse Consultant	T			38
39	Pharmacist Consultant	H	3,527	10-3A	39
40	Physical Therapy Consultant	L	2,606	10-3A	40
41	Occupational Therapy Consultant	Y	72	10-3A	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	F	764	10-3A	43
44	Activity Consultant	E			44
45	Social Service Consultant	E	4,730	12-3	45
46	Other(specify) Dental	S	2,061	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 35,141		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Nivram Management Inc - Management Fees	$ 517,984
TOTAL (agree to Schedule V, line 17, col. 3)	$ 517,984
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kessler, Orlean, Silver & Co	Accounting	$ 25,600
Louise A. Reiff	Legal	1,000
Laner, Munchin, Dombrow	Legal	91
See Attached Schedule		32,348
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,039

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,159
Unemployment Compensation Insurance	53,230
FICA Taxes	190,601
Employee Health Insurance	38,155
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	5,304
Allocation from Management Company	27,092
Employee's Physical Exam	3,575
TOTAL (agree to Schedule V, line 22, col.8)	$ 369,116

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	20,611
Health Care Worker Background Check	
(Indicate # of checks performed)	
Yellow Page Advertising	4,486
See Attached Schedule	8,222
Village of Chicago Ridge	240
CLIA	150
USCIS	570
Allocation from Management Company	202
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(4,486)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,990

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,360
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,360

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Chicago Ridge Nursing Center # 0045815 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Concil Long Term Care $12,414**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **126,819**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **0** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **-0-**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees